



## GENERAL INFORMATION ('MATERNITY SURVEY')

This paper-based form is included in your folder for your information, and in case you do not have access to the internet and need to submit a Case – (*normally you would use the web-based survey to enter data*). If you need to use this form, please copy it first, along with the relevant condition/s.

### Instructions

1. Please do not enter any personally identifiable information (e.g. name, address or hospital number) on this form: all identifying information is entered on the log sheet.
2. Enter this case on your log sheet. Record the ID on the front of this form against the woman's name in your log book (ID number obtained from web system, or contact AMOSS).
3. Fill in the form using the information available in the woman's case notes.
4. Tick the boxes as appropriate. If you require any additional space to answer a question please use the space provided at the end of this General Information or Condition form.
5. Please complete all dates in the format DD/MM/YY, unless otherwise indicated.
6. Please complete all times using the 24hr clock e.g. 14:34.
7. Definition of each variable is contained in the data dictionary (accessed at [www.amoss.com.au](http://www.amoss.com.au))
8. If you encounter any problems with completing this form, please contact the AMOSS Project Coordinator [amoss@uts.edu.au](mailto:amoss@uts.edu.au) or use the space at end of each section to describe the problem.

### Details about the person filling in this form

Name of person completing the form \_\_\_\_\_

Work phone number \_\_\_\_\_

#### Professional group

- |  |                                |
|--|--------------------------------|
| Midwife  | <input type="checkbox"/>       |
| Obstetrician   | <input type="checkbox"/>       |
| Obstetric physician                                  | <input type="checkbox"/>       |
| Maternal Fetal Medicine (MFM) specialist             | <input type="checkbox"/>       |
| Study coordinator (RHD, GBC etc)                     | <input type="checkbox"/>       |
| Health information manager/Quality assurance officer | <input type="checkbox"/>       |
| Anaesthetist   | <input type="checkbox"/>       |
| Cardiologist   | <input type="checkbox"/>       |
| Cardiac nurse  | <input type="checkbox"/>       |
| Renal physician                                      | <input type="checkbox"/>       |
| Renal nurse  | <input type="checkbox"/>       |
| Echotechnician/Echocardiographer                     | <input type="checkbox"/>       |
| Physician/District Medical Officer (DMO)             | <input type="checkbox"/>       |
| RMO/Registrar (specify type of Registrar)            | <input type="checkbox"/>       |
| GP / GP with Obstetric Diploma                       | <input type="checkbox"/>       |
| Remote area nurse (RAN)                              | <input type="checkbox"/>       |
| Registered Nurse (other)                             | <input type="checkbox"/>       |
| Other – please specify                               | <input type="checkbox"/> _____ |

Date data form was completed        /   /

Has the Medical Record Number (MRN) been recorded against the AMOSS Case ID in the Log Sheet?

Yes  No  (If no, please do so now. This is the only identified reference for case queries)

In the case of queries, you may find it useful to keep a copy of this form. *Don't forget to enter the Case details on the Log sheet! Contact AMOSS if you need a new one.* Thank you.

**Section 1: Woman's details**

1.1 Age in years

1.2 What country was the woman born in? \_\_\_\_\_

1.3 Indigenous status

*(Answer only if you are entering the data from an Australian hospital)*

- Aboriginal but not Torres Strait Islander origin
- Torres Strait Islander but not Aboriginal origin
- Both Aboriginal and Torres Strait Islander origin
- Neither Aboriginal nor Torres Strait Islander origin
- Not stated/inadequately described

Maori and or Pacific identification *(Answer only if you are entering the data from an Australian hospital)*

Does the woman identify as a Maori or Pacific Islander?

*(Answer this only if you are entering the data from an Australian site)*

- No  Yes - Pacific Islander  Yes - Maori  Not known

*(Answer this only if you are entering the data from a New Zealand hospital)*

- New Zealand European
- Maori
- Samoan
- Cook Island Maori
- Tongan
- Niuean
- Chinese
- Indian
- Other (please specify)

1.4 Is English the primary language spoken at home? Yes  No  Not known

*(If not English) What is the language spoken at home?*

1.5 Relationship status

- Never married
- Widowed
- Divorced
- Separated
- Married
- De facto
- Not stated

1.6 Residential postcode

1.7 Was the admission as a public or private patient? Private  Public  Not eligible for Medicare

1.8 Date of antenatal booking visit \_\_\_/\_\_\_/\_\_\_

1.9 Height at booking (cm)  cm

1.10 Weight at booking (kg)  kg

1.11 Smoking status

- Never smoked
- Quit smoking before becoming pregnant
- Quit smoking during pregnancy (<20 weeks)
- Quit smoking during pregnancy (≥ 20 weeks)

Continued to smoke during pregnancy	<input type="checkbox"/>
Smoking at booking visit, but not known if continued during pregnancy	<input type="checkbox"/>
Not smoking at booking visit, but not known if smoked during rest of pregnancy	<input type="checkbox"/>
Not known	<input type="checkbox"/>

**Section 2: PREVIOUS pregnancies**

2.1 Has the woman been pregnant before? Yes  No  Not known   
 (If No or Not known please go to Section 3)

2.2 What is the woman's gravidity?    
 (The total number of pregnancies, including the current one)

2.2.1 How many months since preceding birth/pregnancy termination/miscarriage?   months  
 Not known  Not applicable (parity = 0)

2.3 What is the woman's parity?    
 (The number of pregnancies that have resulted in a live birth or stillbirth – excluding current pregnancy)  
 If no previous pregnancies, please go to section 3

2.4 Did this woman have a prior caesarean section? Yes  No  Not known  Not applicable (parity = 0)   
 If yes, how many?    
 Was the immediately preceding birth by caesarean section? Yes  No  Not known

**Section 3: BEFORE this pregnancy**

3.1 Previous or pre-existing medical or obstetric problems (**prior to this pregnancy**)

<b>Neurological</b> (Epilepsy, Migraine, Multiple sclerosis, Meningitis, Spinal cord injury, Myasthenia gravis, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	(if yes, please detail)
<b>Mental health</b> (Anxiety, Depression, Postnatal depression, Puerperal psychosis, Schizophrenia, Bipolar disorder, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Substance use</b> (Methadone/ Buprenorphine opiate substitution therapy, or a known user of illicit drugs, Alcohol abuse)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Circulatory/Cardiac</b> (Atrial fibrillation, Endocarditis, Cardiomyopathy, Cardio-respiratory arrest, Cerebrovascular accident/stroke, Congenital heart disease with follow up in childhood, Hypertension (pre-existing), Ischaemic heart disease, Marfans, Myocardial infarction, Pulmonary oedema, Pulmonary hypertension, Rheumatic fever, Rheumatic heart disease, Thromboembolism, Valve disorder (non-RHD), other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Respiratory</b> (Asthma, Bronchiectasis, Cystic fibrosis, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Gastrointestinal</b> (Gastric banding/stomach stapling, Fatty liver disease, Cholecystitis, Crohns Disease, Ulcerative colitis, Inflammatory bowel disease, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Renal</b> (Recurrent UTIs,	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	

Glomerulonephritis, dialysis, renal transplant, other) (if yes) What was the creatinine level at the booking visit?		Creatinine level (mmol) _____
<b>Endocrine/Nutritional/Metabolic</b> (Diabetes mellitus Type I or Diabetes mellitus II [pre-existing], Pheochromocytoma, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Haematological</b> (Nutritional anaemia, pulmonary embolism, deep vein thrombosis, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Musculoskeletal and connective</b> Systemic lupus erythematosus (SLE), other	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Neoplasms</b> (cervical cancer, gestational trophoblastic tumour, gestational breast cancer, Indicate type and if current or previous)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Infections</b> (Influenza A, Streptococcus A, Hepatitis, Acute rheumatic fever, Syphilis, HIV, Tuberculosis, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Obstetric</b> (Gestational diabetes mellitus, Gestational trophoblastic tumour, Gestational hypertension, Pre-eclampsia, Eclampsia, Chorioamnionitis, Breech, premature rupture of membranes, Retained placenta, Obstetric tear (3 <sup>rd</sup> or 4 <sup>th</sup> degree), Uterine rupture, amniotic fluid embolism, pulmonary embolism, Retained placenta, Placenta accrete or other placental abnormalities, Primary or secondary haemorrhage (more than 1000 mls), Vasa praevia, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Fetal and newborn</b> (Antepartum stillbirth, Intrapartum stillbirth, Stillbirth not specified, Neonatal death, Congenital anomaly, Intra-uterine growth restriction, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Any other previous or pre-existing medical or obstetric problems not included above?</b> (please specify)		

**Sections 4 & 5: THIS pregnancy**

- 4.1 What is the estimated date of birth? (EDB / EDC) / /
- 4.2 Was this pregnancy the result of assisted reproductive technology? Yes  No  Not known
- 4.3 Was this a multiple pregnancy? Yes  No  Not known   
If yes, please specify the number of fetuses

**Model of Care**

- 4.4 Please select the antenatal allocated model of care at the booking of pregnancy.  
(Answer only if you are entering the data from an Australian hospital)
- Private obstetrician (specialist) care
- Private midwifery care
- General practitioner obstetrician care
- Shared care
- Combined care

	Public hospital maternity care	<input type="checkbox"/>
	High risk public hospital maternity care	<input type="checkbox"/>
	Team midwifery care	<input type="checkbox"/>
	Midwifery group practice caseload care	<input type="checkbox"/>
	Remote area care	<input type="checkbox"/>
	No formal care	<input type="checkbox"/>
	Other <input type="checkbox"/> Specify _____	
4.4 a	Did this model of care change during this pregnancy? Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/> ( <i>Aust only</i> )	
4.4.b	If yes, at what gestational age? <input type="checkbox"/> <input type="checkbox"/> ( <i>Aust only</i> )	
4.4.c	The model of care was changed to: ( <i>Aust only</i> )	
	Private obstetrician (specialist) care	<input type="checkbox"/>
	Private midwifery care	<input type="checkbox"/>
	General Practitioner obstetrician care	<input type="checkbox"/>
	Shared care	<input type="checkbox"/>
	Combined care	<input type="checkbox"/>
	Public hospital maternity care	<input type="checkbox"/>
	High risk public hospital maternity care	<input type="checkbox"/>
	Team midwifery care	<input type="checkbox"/>
	Midwifery group practice caseload care	<input type="checkbox"/>
	Remote area care	<input type="checkbox"/>
	No formal care	<input type="checkbox"/>
	Other <input type="checkbox"/> Specify _____	
4.4	Did mother have an identified lead maternity carer (LMC) during pregnancy? Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/> ( <i>Answer this only if you are entering the data from a New Zealand hospital</i> )	
4.4a	Who was the mother's Lead Maternity Carer at booking? ( <i>NZ only</i> )	
	Self employed midwife	<input type="checkbox"/>
	Hospital employed midwife	<input type="checkbox"/>
	Hospital antenatal clinic	<input type="checkbox"/>
	High-risk/maternal fetal medicine	<input type="checkbox"/>
	General practitioner	<input type="checkbox"/>
	Obstetrician (private)	<input type="checkbox"/>
	Other <input type="checkbox"/> - Specify _____	
4.4b	Who was the mother's Lead Maternity Carer at birth? ( <i>NZ only</i> )	
	Self employed midwife	<input type="checkbox"/>
	Hospital employed midwife	<input type="checkbox"/>
	Hospital antenatal clinic	<input type="checkbox"/>
	High-risk/maternal fetal medicine	<input type="checkbox"/>
	General practitioner	<input type="checkbox"/>
	Obstetrician (private)	<input type="checkbox"/>
	Not applicable	<input type="checkbox"/>
	Other <input type="checkbox"/> -	
4.4c	Specify details if the Lead Maternity Carer not listed, and indicate whether at booking or birth (or both). If not relevant enter N/A  _____	

**Transfer**

4.5 Was the woman transferred during antenatal period? Yes  No  Not known

4.5a (If yes) Was she transferred TO your hospital from another facility? Yes  No  Not known

4.5b Was she transferred FROM your hospital? Yes  No  Not known

4.5c At what gestational age was the woman transferred?   weeks

4.5d What was the *main* reason for the transfer?

Identified high-risk

Hospital protocol

After diagnosis of the condition being studied

Preempt complications resulting from the condition being studied

Access to facilities (eg specialist cardiac or oncology)

Other  - Specify \_\_\_\_\_

Not known

4.5e Details of transfer (specify reason for transfer if not listed above, and give details related to transfer)

4.6 Are all women transferred out of their community to give birth? Yes  No  Not known

**Medication**

4.7 Did the woman use any prescribed medication during the pregnancy? Yes  No  Not known   
If yes, please list \_\_\_\_\_

4.8 Were there any prescribed medication ceased because of this pregnancy? Yes  No  Not known   
If yes, please list \_\_\_\_\_

4.9 Was the woman immunised against Influenza? Yes  No  Not known

**Section 5 This Pregnancy**

5.1 Obstetric/medical problems during *this* pregnancy (before birth)?

<b>Neurological</b> Epilepsy, Multiple sclerosis, Myasthenia gravis, other	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	(if yes, please detail including date/s and management)
<b>Mental health</b> (eg Anxiety, Depression, Puerperal psychosis, Schizophrenia, Bipolar disorder, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Substance use:</b> (Methadone/ Buprenorphine opiate substitution therapy, or a known user of illicit drugs during pregnancy; Alcohol abuse)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Circulatory/Cardiac</b> (Atrial fibrillation, Endocarditis, Cardiomyopathy, Cardio-respiratory arrest, Cerebrovascular accident/stroke, Essential hypertension, Congenital heart disease, Ischaemic heart disease, Marfans, Myocardial infarction, Pulmonary oedema, Pulmonary hypertension, Rheumatic fever, Rheumatic heart disease, Thromboembolism, Valve disorder (non-RHD), other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
<b>Respiratory</b> (Asthma, Bronchiectasis, Cystic fibrosis, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	

<p><b>Gastrointestinal</b> (Gastric banding/stomach stapling, Fatty liver disease, Cholecystitis, Crohns Disease, Ulcerative colitis, Inflammatory bowel disease, other)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/></p>	
<p><b>Renal</b> (Recurrent UTIs, Glomerulonephritis, dialysis, renal transplant, other) (if yes) What was the creatinine level at the booking visit?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>  Creatinine level (mmol) _____</p>	
<p><b>Endocrine/Nutritional/Metabolic</b> (Diabetes mellitus Type I or II [pre-existing], Pheochromocytoma, other)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/></p>	
<p><b>Haematological</b> (Nutritional anaemia, Pulmonary embolism, Deep vein thrombosis, Thrombocytopenia, other)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/></p>	
<p><b>Musculoskeletal and connective</b> Systemic lupus erythematosus (SLE), other</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/></p>	
<p><b>Neoplasms</b> (Cervical cancer, Gestational breast cancer (Indicate type and if diagnoses during this pregnancy or recurrence), other</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/></p>	
<p><b>Infections</b> Influenza A, Streptococcus A or B, Hepatitis, Acute rheumatic fever, Syphilis, HIV/AIDS, Tuberculosis, Listeria, Toxoplasmosis, Cytomegalovirus(CMV), other</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/></p>	
<p><b>Obstetric</b> (Gestational diabetes mellitus, Gestational hypertension, Pre-eclampsia, Eclampsia, Antepartum haemorrhage, Threatened premature labour, Placenta accrete or other placental abnormalities, Vasa praevia, Chorioamnionitis, Antenatal pulmonary embolism, Other – give details)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/></p>	
<p><b>Surgery during pregnancy?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/></p>	
<p><b>Other</b> (please specify)</p> <hr/>		
<p><b>Give details of diagnosis, management and outcomes</b></p>		

5.2 Was the woman admitted to antenatal ward, ICU, CCU or HDU for higher care during pregnancy (before birth)?

No

Yes, antenatal ward or higher dependency unit

Yes, ICU

Yes, Coronary Care Unit (CCU)

Yes, Antenatal and ICU

Yes, Antenatal and CCU

Yes, ICU and CCU

Other (specify)

For each admission, state admission and discharge dates, indication, and treatment given.

5.2b Gestation at admission  weeks (if multiple admissions, indicate here) \_\_\_\_\_

5.2c Total number of days  days (in any unit)

Not known

Please specify reason and management \_\_\_\_\_

5.3 What is the current status of this pregnancy?

Given birth  Still pregnant

**Section 6: Labour and birth details**

6.1 Did the woman labour? Yes  No  Not known

If yes, please state date and time of onset of labour / /  : :

If no, go to 2.2

6.1a Was labour induced? Yes  No  Not known

6.1b Was labour augmented? Yes  No  Not known

6.1c Did the membranes rupture spontaneously? Yes  No  Not known

6.1d Was syntocinon used during labour? Yes  No  Not known

6.1e Was a prostaglandin used before or during labour? Yes  No  Not known

6.1f Length of labour 1st stage :  2nd stage :  3rd stage :

6.2 Was birth by caesarean section? Yes  No  Not known

6.2a If yes, please state the urgency of caesarean section

RANZCOG Category 1

RANZCOG Category 2

RANZCOG Category 3

RANZCOG Category 4

Not Known

6.2b Please give the indication for caesarean section

**Obstetric indication**

Not relevant: no obstetric indication

Poor progress in labour

Delay in second stage

Failure to establish labour

High presenting part

Hypertension

Poor descent

Cord prolapse/presentation

Placenta praevia

Abruption placenta



Antepartum or intrapartum haemorrhage	<input type="checkbox"/>
Vasa praevia	<input type="checkbox"/>
Previous caesarean section	<input type="checkbox"/>
Failed instrumental delivery	<input type="checkbox"/>
Not known	<input type="checkbox"/>
<b>Maternal indication</b>	<input type="checkbox"/>
Not relevant: no maternal indication	<input type="checkbox"/>
Previous uterine surgery (excluding C/S)	<input type="checkbox"/>
Active genital herpes	<input type="checkbox"/>
Uterine anomaly	<input type="checkbox"/>
Fibroid/ pelvic mass stenosis	<input type="checkbox"/>
Maternal disease/surgery related to the condition being studied	<input type="checkbox"/>
Maternal disease/surgery not related to the condition being studied	<input type="checkbox"/>
Maternal request	<input type="checkbox"/>
Maternal exhaustion	<input type="checkbox"/>
Not known	<input type="checkbox"/>
<b>Fetal indication</b>	<input type="checkbox"/>
<b>Not relevant: no fetal indication</b>	<input type="checkbox"/>
Non-reassuring FHR trace	<input type="checkbox"/>
Non-reassuring FBS	<input type="checkbox"/>
Abnormal fetal welfare studies	<input type="checkbox"/>
Fetal growth restriction	<input type="checkbox"/>
Breech/face/brow presentation	<input type="checkbox"/>
Oblique/transverse lie	<input type="checkbox"/>
Multiple fetus	<input type="checkbox"/>
Fetal abnormality	<input type="checkbox"/>
Not known	<input type="checkbox"/>
<b>Other indication</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>
If yes, please specify _____	
6.3	Please indicate any analgesia or anaesthesia used during labour and birth
	Nil <input type="checkbox"/>
	Nitrous oxide <input type="checkbox"/>
	Systemic opioids <input type="checkbox"/>
	Pudendal or caudal block <input type="checkbox"/>
	Epidural <input type="checkbox"/>
	Spinal <input type="checkbox"/>
	Combined spinal – epidural <input type="checkbox"/>
	General anaesthesia <input type="checkbox"/>
	Other <input type="checkbox"/>
_____	

**Section 7: Maternal Outcomes**

7.1 Did the woman experience a major postpartum haemorrhage? (estimated blood loss > 1000ml) Yes  No   
 Not known

If yes:

At Birth   
 During the first 24 hours after birth (primary postpartum haemorrhage)  After 24 hours postpartum  
 (secondary postpartum haemorrhage)   
 Not Known

7.1a (If yes) What was the estimated blood loss? \_\_\_\_\_ ml

7.1b Did the woman have blood products because of this postpartum haemorrhage? Yes  No  Not known   
 If yes, how many units of blood products did the woman have?

7.1c

What treatment(s) were used to control bleeding? **Uterotonic interventions:**

Syntocinon infusion Yes  No  Not known   
 Syntometrine Yes  No  Not known   
 Prostaglandin F2 $\alpha$  Yes  No  Not known   
 Misoprostol Yes  No  Not known  Tranexamic acid  
 Yes  No  Not known

**Transfusion support:**

Recombinant Factor VIIa Yes  No  Not known   
 Fibrinogen concentrate Yes  No  Not known   
 Prothrombin complex concentrate Yes  No  Not known

**Surgical/radiological interventions:**

Suturing of perineal tears/lower genital tract trauma Yes  No  Not known   
 Examination under anaesthesia and manual removal  
 of placenta/retained products Yes  No  Not known   
 Intra-abdominal packing Yes  No  Not known   
 Intra-uterine balloon Yes  No  Not known   
 Intra-uterine packing Yes  No  Not known   
 Vessel embolization (radiological) Yes  No  Not known   
 Vessel ligation Yes  No  Not known   
 Intra-arterial balloons (radiology – guided) Yes  No  Not known   
 B-Lynch or other brace sutures Yes  No  Not known   
 Other Yes  No  Not known   
 If other, please specify \_\_\_\_\_  
 \_\_\_\_\_

7.2 Did the woman have a hysterectomy? Yes  No  Not known

7.3-7.7 Did any of the following morbidities occur?

<b>Other Obstetric</b> (Eclampsia, Prolonged rupture of membranes, Shoulder dystocia, Retained placenta, Obstetric 3rd or 4 <sup>th</sup> degree tear, Uterine rupture, Amniotic embolism, Puerperal sepsis, Placenta accrete or other placental abnormalities, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>
<b>Cardiac/circulatory</b> (Atrial fibrillation, Endocarditis, Cardiomyopathy, Cardio respiratory arrest, Cerebrovascular accident/ stroke, Essential hypertension, Intracerebral bleed, Ischaemic heart disease, Myocardial infarction, Peripartum cardiomyopathy, Pulmonary oedema, Pulmonary hypertension, Rheumatic fever, Rheumatic heart disease, Thromboembolism, Valve disorder (non-RHD), other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>
<b>Mental health</b> (Puerperal psychosis, Withdrawal from opiates or sedatives, Withdrawal from alcohol, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>
<b>Infections</b> (MRSA, Wound infection, other)	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>

**Other** (please specify) \_\_\_\_\_

**Give details of diagnosis, management and outcomes**

7.8 Did the woman go/return to operating theatre within 48 hours of giving birth? Yes  No  Not known   
 (If yes) Give details \_\_\_\_\_

7.9 Was the woman admitted to ICU? Yes  No  Not known  (If yes) How many days? \_\_\_\_\_

7.10 Was the woman admitted to Cardiac Care Unit (CCU)?  
 Yes  No  Not known  (If yes) How many days? \_\_\_\_\_

7.11 Was the woman admitted to High Dependency Unit (HDU)? Yes  No  Not known  (If yes) How many days? \_\_\_\_\_

7.12 Was the woman managed in BS (Birthing suite) (or other unit that provides additional care and monitoring) postpartum? Yes  No  Not known

**Separation status**

7.13 Was the woman transferred to/from your hospital *during labour*? Yes  No  Not known   
 (If yes) Transferred *from* our hospital? Yes  No  Not known   
 Transferred *to* our hospital? Yes  No  Not known   
 Transferred TO our hospital, then transferred back to the original hospital Yes  No  Not known   
 Transferred TO our hospital, then transferred to another hospital Yes  No  Not known

(If yes) Reason for transfer:  
 Maternal or fetal complication not related to the condition being studied   
 Due to diagnosis of the condition being studied   
 Not known   
 Other/give details \_\_\_\_\_

7.14 Was the woman discharged home from hospital Yes  No  Not known

7.15 Was the woman transferred to/from your hospital *postpartum*? Yes  No  Not known   
 (If yes) Transferred *from* our hospital? Yes  No  Not known   
 Transferred *to* our hospital? Yes  No  Not known   
 Transferred TO our hospital, then transferred back to the original hospital Yes  No  Not known   
 Transferred TO our hospital, then transferred to another hospital Yes  No  Not known

(If yes) What was the *main* reason for transfer:

	Return to local hospital/community	<input type="checkbox"/>
	Maternal complications not related to the condition being studied	<input type="checkbox"/>
	Maternal complication related to the condition being studied	<input type="checkbox"/>
	Accompany baby being transferred to a higher level care hospital	<input type="checkbox"/>
	Woman's choice	<input type="checkbox"/>
	Not known	<input type="checkbox"/>
	Other	<input type="checkbox"/>
	If other, please specify _____	
7.16	What was the <i>total</i> length of stay in the hospital? _____ days	
7.17	Did the woman die?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>
7.17a	If yes, please specify date of death	<input type="text"/> / <input type="text"/> / <input type="text"/>
7.17b	What was the primary cause of death, as stated on the death certificate?	_____
7.17c	Was a postmortem examination undertaken?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>

<b>Section 8: Infant Outcomes</b> <i>Please print out another copy of page for each infant if more than one:</i>			
8.1	Date and time of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> : <input type="text"/>
8.2	<b>Place of birth (select one):</b>		
	Birth suite	<input type="checkbox"/>	
	Operating theatre	<input type="checkbox"/>	
	Intensive care unit	<input type="checkbox"/>	
	Cardiac care unit	<input type="checkbox"/>	
	Emergency department	<input type="checkbox"/>	
	Other (detail) _____		
8.3	<b>Mode of birth</b>		
	Unassisted vaginal birth (vertex)	<input type="checkbox"/>	
	Forceps	<input type="checkbox"/>	
	Vacuum extraction	<input type="checkbox"/>	
	Caesarean section	<input type="checkbox"/>	
	Vaginal breech	<input type="checkbox"/>	
	Frank	<input type="checkbox"/>	
	Complete	<input type="checkbox"/>	
	Footling	<input type="checkbox"/>	
	Kneeling (incomplete)	<input type="checkbox"/>	
	Not known	<input type="checkbox"/>	
	<i>(If breech)</i>		
	Did the woman have ECV (External cephalic version)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
	ECV available and accepted	<input type="checkbox"/>	ECV not available <input type="checkbox"/>
	ECV contraindicated	<input type="checkbox"/>	
	ECV available not offered	<input type="checkbox"/>	
	ECV available declined	<input type="checkbox"/>	
	Not known	<input type="checkbox"/>	
8.4	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not stated <input type="checkbox"/>	
8.5	Birth gestation (completed weeks)	<input type="text"/> <input type="text"/> weeks	

8.6	Birth weight (g)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	grams
8.7	What was the birth order of this neonate?		
	Singleton or first birth of a multiple birth	<input type="checkbox"/>	
	Second of a multiple birth	<input type="checkbox"/>	
	Third of a multiple birth	<input type="checkbox"/>	
	Fourth of a multiple birth	<input type="checkbox"/>	
	Fifth of a multiple birth	<input type="checkbox"/>	
	Sixth of a multiple birth	<input type="checkbox"/>	
	Other	<input type="checkbox"/>	
	Not stated	<input type="checkbox"/>	
8.8	What was the infant's condition at birth?		
	Live born	<input type="checkbox"/>	
	Ante-partum Stillborn	<input type="checkbox"/>	
	Intra-partum Stillborn	<input type="checkbox"/>	
	Stillborn (not specified)	<input type="checkbox"/>	
	<i>(If stillborn, go to question 8.8)</i>		
	Not known	<input type="checkbox"/>	
8.8a	What was the 5 minute Apgar score?	<input type="checkbox"/>	
8.8b-c	Was the infant admitted to the Neonatal intensive care unit or Special care nursery?		
	Neonatal intensive care unit	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
	Special care nursery	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>	
8.8d	Did the infant require resuscitation measures?		
	No	<input type="checkbox"/>	
	Oxygen	<input type="checkbox"/>	
	Neopuff or CPAP mask only	<input type="checkbox"/>	
	Suction	<input type="checkbox"/>	
	Neopuff or CPAP mask + Suction + Oxygen	<input type="checkbox"/>	
	Intubated with CPAP only		
	Intubated with IPP (intermittent positive pressure)		
	IPP intubation + Cardiac compression	<input type="checkbox"/>	
	Cardiac compression	<input type="checkbox"/>	
	Resuscitation drugs (nalaxone, adrenaline etc)	<input type="checkbox"/>	
	Resuscitation drugs + IPP intubation + Cardiac compression	<input type="checkbox"/>	
	All of the above	<input type="checkbox"/>	
	Other	<input type="checkbox"/>	
	Not known	<input type="checkbox"/>	
8.8e	Did the infant require any further respiratory support?		
	No	<input type="checkbox"/>	
	High flow nasal cannula	<input type="checkbox"/>	
	CPAP mask only	<input type="checkbox"/>	
	Intubated with CPAP only	<input type="checkbox"/>	
	Intubated with IPP (intermittent positive pressure ventilation)	<input type="checkbox"/>	
	IMV (intermittent mandatory ventilation)	<input type="checkbox"/>	
	HFOV (high frequency oscillatory ventilation)	<input type="checkbox"/>	
	Other	<input type="checkbox"/>	
8.8e	Did any major infant complications occur? Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>		
	If yes, please specify		
	_____		
8.9	Was the baby born with any congenital malformations? Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>		
	If yes, please specify		
	_____		

8.10 What was the separation status of the infant?

- Discharged home
- Transferred to another health facility
- Died

8.10a If the infant died, please specify the date of death        /   /

8.10b What was the primary cause of death, as stated on the death certificate?  
\_\_\_\_\_

8.10c Was an autopsy performed?      Yes  No  Not known

8.11 Any other information?

Please use this space to enter any other information you feel may be important

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*(Now complete the condition specific survey/s. Thanks!)*